# Open Access Plan (OAP) Benefits

The benefits described below represent the minimum level of coverage available in an OAP. Benefits are outlined in the plan's summary plan document (SPD). It is the member's responsibility to know and follow the specific requirements of the OAP plan. Contact the plan for a copy of the SPD. A $100 prescription deductible applies to each plan participant.

| Benefit | Tier I<br>100% Benefit | Tier II<br>90% Benefit | Tier III (Out-of-Network)<br>60% Benefit |
|---|---|---|---|
| Plan Year Maximum Benefit | Unlimited | Unlimited | Unlimited |
| Lifetime Maximum Benefit | Unlimited | Unlimited | Unlimited |
| Annual Out-of-Pocket Max<br>Per Individual Enrollee<br>Per Family | $6,250 (includes eligible charges from Tier I and Tier II combined)<br>$12,700 (includes eligible charges from Tier I and Tier II combined) | | Not Applicable |
| Annual Plan Deductible (must be satisfied for all services) | $0 | $250 per enrollee* | $350 per enrollee* |
| **Hospital Services** | | | |
| Inpatient | 100% after $350 copayment per admission | 90% of network charges after $400 copayment per admission | 60% of allowable charges after $500 copayment per admission |
| Inpatient Psychiatric | 100% after $350 copayment per admission | 90% of network charges after $400 copayment per admission | 60% of allowable charges after $500 copayment per admission |
| Inpatient Alcohol and Substance Abuse | 100% after $350 copayment per admission | 90% of network charges after $400 copayment per admission | 60% of allowable charges after $500 copayment per admission |
| Emergency Room | 100% after $250 copayment per visit | 100% after $250 copayment per visit | 100% after $250 copayment per visit |
| Outpatient Surgery | 100% after $250 copayment per visit | 90% of network charges after $250 copayment | 60% of allowable charges after $250 copayment |
| Diagnostic Lab and X-ray | 100% | 90% of network charges | 60% of allowable charges |
| **Physician and Other Professional Services**<br>(Copayment not required for preventive services) | | | |
| Physician Office Visits | 100% after $20 copayment | 90% of network charges | 60% of allowable charges |
| Specialist Office Visits | 100% after $30 copayment | 90% of network charges | 60% of allowable charges |
| Preventive Services, including immunizations | 100% | 100% | Covered under Tier I and Tier II only |
| Well Baby Care (first year of life) | 100% | 100% | Covered under Tier I and Tier II only |
| Outpatient Psychiatric and Substance Abuse | 100% after $20 or $30 copayment | 90% of network charges | 60% of allowable charges |
| **Other Services** | | | |
| Prescription Drugs – Covered through State of Illinois administered plan, Express Scripts; $100 deductible applies<br>Generic $8 Preferred Brand $26 Nonpreferred Brand $50 | | | |
| Durable Medical Equipment | 80% of network charges | 80% of network charges | 60% of allowable charges |
| Skilled Nursing Facility | 100% | 90% of network charges | Covered under Tier I and Tier II only |
| Transplant Coverage | 100% | 90% of network charges | Covered under Tier I and Tier II only |
| Home Health Care | 100% after $30 copayment | 90% of network charges | Covered under Tier I and Tier II only |

* An annual plan deductible must be met before Tier II and Tier III plan benefits apply. Benefit limits are measured on a plan year. Amounts over the plan's allowable charges do not count toward the out-of-pocket maximum.